

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 004016	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/07/2015
NAME OF PROVIDER OR SUPPLIER MONROE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 2770 S ADAMS RD BLOOMINGTON, IN 47403		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00175203.</p> <p>Complaint IN00175203 - Unsubstantiated due to lack of evidence.</p> <p>Survey date: July 7, 2015</p> <p>Facility number: 004016 Provider number: 004016 AIM number: N/A</p> <p>Census bed type: Residential: 48 Total: 48</p> <p>Sample: 03</p> <p>Monroe Place was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00175203.</p>	R 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE